State of New Mexico
Medical Assistance Program Manual
Supplement

DATE: April 27, 2012 **NUMBER:12-04**

TO: ALL HOSPITAL PROVIDERS IN THE NEW MEXICO MEDICAID PROGRAM

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SUBJECTS: I. REQUIREMENTS WHEN BILLING FOR SPECIFIC PROCEDURE CODES
II. REQUIREMENTS WHEN BILLING FOR DENTAL CODES

I. REQUIREMENTS WHEN BILLING FOR SPECIFIC PROCEDURE CODES

This information is being provided to remind providers of federal requirements and to provide more specific information for the New Mexico Medicaid Fee-for-Service program.

The Centers for Medicare and Medicaid Services (CMS) has announced that drug rebates for the Medicaid program cannot be collected on claims for practitioner administered drug items for which no payment has been paid because the Outpatient Prospective Payment System (OPPS) considers the payment to be "packaged". Therefore, the list of procedure codes that now require the National Drug Code (NDC) for hospitals is significantly smaller than the list of those codes requiring NDCs given in previous supplements.

The federal Deficit Reduction Act of 2005 (signed in 2006) requires Medicaid providers to report the 11-digit NDC on the CMS1500 and UB04 claim forms as well as on the 837 electronic transactions when billing for injections and other drug items administered in outpatient offices, hospitals, and other clinical settings.

Physician and hospital providers were first notified of this upcoming requirement in November 2007, in the supplement 07-09, available on the Medical Assistance Division (MAD) website at: http://www.hsd.state.nm.us/mad/pdf_files/Supplements/MAD_REG_S_07-09.pdf

Providers were again notified in May 2010 of the requirement, in supplement 10-03, which also can be found on the MAD website at:
http://www.hsd.state.nm.us/mad/pdf_files/Registers/Registers2010/10%2003%20pharmacy.pdf

MAD implemented the requirement that providers must include the appropriate NDC and other essential information on the claim when billing for drug items. If a provider has not already done so, it may be necessary to contact the software vendors to modify billing software.

ACS will deny all claims from hospital providers that do not indicate a valid NDC when the HCPCS code otherwise would be payable under OPPS.

The NDC code is not required for claim lines that are being denied because the OPPS pricing source is J7-OPPS Procedure Not Covered, JB-OPPS Not Covered, JC-OPPS Not Covered Inpatient Service, JE-OPPS Not Covered, JM-OPPS Not Covered or JY-OPPS Not Covered.

In addition, claim lines with the OPPS pricing source code JN- OPPS Packaged Service will pay zero when the valid NDC code is present and will be denied when the NDC code is not present. The OPPS pricing source codes are subject to revision as CMS revised the APC status indicators.

Providers are advised to check the Fee Schedule section on the MAD website, under Provider Information, Enrollment & Program Policy, and then under Fee-for-Service and Fee Schedules, or at http://www.hsd.state.nm.us/mad/PFeeSchedules.html for the list of procedure codes that require a NDC, and for any updates that may occur in the future.

Providers paid on the basis of an encounter rate such as an FQHC, an IHS or tribal compact facility or a bundled rate such as drugs included in a dialysis cap charge do not need to supply an NDC code because they are not reimbursed using the revenue codes found on the above mentioned list.

Understanding the National Drug Code (NDC) :

The NDC code, which is found on the label of a prescription drug item, must be included on the UB04 claim form or in the 837 electronic transaction. The NDC is a universal number that identifies a drug. The complete NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2 format such as "12345-1234-12."
However, sometimes the NDC as printed on a drug item omits a leading zero in one of the segments, requiring a leading zero to be entered on the claim form and the hyphens to not be used. Instead of the digits and hyphens being in a 5-4-2 format, the NDC may be indicated in a 4-4-2 as in "1234-1234-1", or in a 5-3-2 format as in "12345-123-12", or less commonly in a 5-4-1 format as in 12345-1234-1."
A leading zero must be added to make the 5-4-2 format. See the following examples:

NDC 12345-1234-12 is complete – it is reported as 12345123412

NDC 1234-1234-12 needs a leading zero in the first segment to be in the 5-4-2 digit format, to become 01234-1234-12 – it is reported as 01234123412

NDC 12345-234-12 needs a leading zero in the second segment to be in the 5-4-2 digit format, to become 12345-0234-12 – it is reported as 12345023412

NDC 12345-1234-1 needs a leading zero in the third segment to be in the 5-4-2 digit format, to become 12345-1234-01 – it is reported as 12344512301

INSTRUCTIONS FOR BILLING DRUG ITEMS ADMINISTERED IN OUTPATIENT CLINICS AND HOSPITALS

Because reporting the NDC code requires providers to use both the upper and lower rows on a claim line, be certain to line up the information accurately so that all characters fall within the proper box and row.

UB04 FORM

Even though an NDC is entered, a valid revenue code must be entered in form locator 42 and a HCPCS or CPT code must be entered in form locator 44.

The NDC must be entered in box 43, which is currently labeled as "description". Beginning at the left edge of form locator 43, enter the 2-digit qualifier "N4" immediately followed by the 11-digit NDC. An example of an entry for the NDC code 00054352763 will be: N400054352763.

Enter NDC in box 43

Optional Information:

While the minimal new information required by MAD is the qualifier, the NDC and correct reporting of units for the HCPCS or CPT code, there are additional national standards for reporting more information on drug items that other payers may eventually require. MAD is also capable of receiving the additional information when submitted on a claim but it is not required at this time. A provider changing their billing system may want to also add information according to the following format:

- At the left edge of form locator 43, enter the 2-digit qualifier "N4" immediately followed by the 11-digit NDC, followed by 3 spaces, followed by one of the four (4) qualifiers for unit of measurement followed immediately by the quantity.
- The four (4) units of measure qualifiers are:

F2 – International Unit	GR – Gram
ML – Milliliter	UN – Units

II. REQUIREMENTS WHEN BILLING FOR DENTAL CODES

Most dental care is provided in an office setting using local anesthetics. Under certain circumstances, it is necessary to perform these procedures in a hospital or outpatient surgical facility using intravenous sedation or general anesthesia. To bill for the facility charge in these circumstances, a hospital must bill for hospital-based dental services on the UB claim form, using HCPCS procedure codes that begin with a "D" (the American Dental Association codes). The hospital must bill a line for each dental service.

Example: If the following was performed on a patient in a hospital:
D0270 : bitewing, single film
D2932 : prefabricated resin crown for one tooth
D2330 : resin-based composite – one surface, anterior
D2331 : resin based composite – two surfaces, anterior on **4** different teeth

The hospital would bill one line for each service and bill one unit on each line:
Line 1: D0270
Line 2: D2932
Line 3: D2330
Line 4: D2331
Line 5: D2331
Line 6: D2331
Line 7: D2331

The first line would pay $694.11, and the next six lines would pay 50% of the $694.11.

The following ADA dental codes may be used by a hospital:

D0120	PERIODIC ORAL EVALUATION	D1550	RECEMENTATION OF SPACE MAINTAINER
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	D2140	AMALGAM ONE SURFACE PERMANEN
D0150	COMPREHENSVE ORAL EVALUATION	D2150	AMALGAM TWO SURFACES PERMANE
D0210	INTRAORAL - COMPLETE SERIES (INCLUDING B	D2160	AMALGAM THREE SURFACES PERMA
D0220	INTRAORAL - PERIAPICAL SINGLE, FIRST FIL	D2161	AMALGAM 4 OR > SURFACES PERM
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL F	D2330	RESIN-ONE SURFACE, ANTERIOR
D0240	INTRAORAL - OCCLUSAL	D2331	RESIN-TWO SURFACES, ANTERIOR
D0250	EXTRAORAL, SINGLE FIRST FILM	D2332	RESIN-THREE SURFACES, ANTERIOR
D0260	EXTRAORAL - EACH ADDITIONAL FILM	D2335	RESIN-FOUR OR MORE SURFACES OR INVOLVING
D0270	BITEWING - SINGLE FILM	D2390	ANT RESIN-BASED CMPST CROWN
D0272	BITEWINGS - TWO FILMS	D2391	POST 1 SRFC RESINBASED CMPST
D0274	BITEWINGS - FOUR FILMS	D2392	POST 2 SRFC RESINBASED CMPST
D0290	POSTEROANTERIOR AND LATERAL SKULL AND FA	D2393	POST 3 SRFC RESINBASED CMPST
D0310	SIALOGRAPHY	D2394	POST >=4SRFC RESINBASE CMPST
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCL	D2710	CROWN RESIN-BASED INDIRECT
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS, BY	D2751	CROWN-PROCELAIN FUSED TO PREDOMINANTLY B
D0330	PANORAMIC - MAXILLA AND MANDIBLE FILM	D2752	CROWN- PORCELAIN FUSED TO NOBLE METAL
D0340	CEPHALOMETRIC FILM	D2791	CROWN-FULL CAST PREDOMINATLY BASE METAL
D1110	PROPHYLAXIS, ADULTS	D2792	CROWN- FULL CAST NOBLE METAL
D1120	PROPHYLAXIS, CHILDREN	D2910	RECEMENT INLAY ONLAY OR PART
D1203	TOPICAL APP FLUORIDE CHILD	D2920	RECEMENT CROWNS
D1204	TOPICAL APP FLUORIDE ADULT	D2930	PREFABRICATED STAINLESS STEEL CROWN- PRI
D1351	SEALANT- PER TOOTH	D2931	PREFABRICATED STAINLESS STEEL CROWN- PER
D1510	SPACE MAINTAINERS, FIXED UNILATERAL TYPE	D2932	PREFABRICATED RESIN CROWN
D1515	SPACE MAINTAINERS, FIXED BILATERAL TYPE	D2933	PREFABRICATED STAINLESS STEEL CROWN WITH

D2934	PREFAB STEEL CROWN PRIMARY	D7270	TOOTH REIMPLANTATION
D2940	PROTECTIVE RESTORATION	D7280	EXPOSURE IMPACT TOOTH ORTHOD
D2950	CORE BUILD-UP, INCLUDING ANY PINS	D7285	BIOPSY OF ORAL TISSUE (HARD)
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO	D7286	BIOPSY OF ORAL TISSUE SOFT
D2952	POST AND CORE CAST + CROWN	D7290	SURGICAL REPOSITIONING OF TEETH
D2953	EACH ADDTNL CAST POST	D7320	ALVEOPLASTY W/O EXTRACTION
D2954	PREFABRICATED POST AND CORE IN ADDITION	D7340	VESTIBULOPLASTY- RIDGE EXTENSION (SECOND
D2957	EACH ADDITIONAL PREFABRICATED POST SAME	D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDI
D3220	THERAPEUTIC PULPOTMOY (EXCLUDING FINAL R	D7410	RAD EXC LESION UP TO 1.25 CM
D3222	PART PULP FOR APEXOGENESIS	D7411	EXCISION BENIGN LESION>1.25C
D3310	END THXPY, ANTERIOR TOOTH	D7412	EXCISION BENIGN LESION COMPL
D3320	END THXPY, BICUSPID TOOTH	D7440	EXCISION OF MALIGNANT TUMOR, LESION DIAM
D3330	END THXPY, MOLAR	D7441	EXCISION OF MALIGNANT TUMOR, LESION DIAM
D3351	APEXIFICATION/RECALC INITIAL	D7450	REM ODONTOGEN CYST TO 1.25CM
D3352	APEXIFICATION/RECALC INTERIM	D7451	REM ODONTOGEN CYST > 1.25 CM
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISI	D7460	REM NONODONTO CYST TO 1.25CM
D3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERI	D7461	REM NONODONTO CYST > 1.25 CM
D3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSP	D7465	DESTRUCTION OF LESIONS BY PHYSICAL METHO
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR	D7471	REM EXOSTOSIS ANY SITE
D3426	APICOECTOMY/PERIRADICULAR SURGERY (EACH	D7472	REMOVAL OF TORUS PALATINUS
D3430	RETROGRADE FILLING - PER ROOT	D7473	REMOVE TORUS MANDIBULARIS
D3450	ROOT AMPUTATION- PER ROOT	D7490	MAXILLA OR MANDIBLE RESECTIO
D4210	GINGIVECTOMY/PLASTY PER QUAD	D7510	INCISION AND DRAINAGE OF ABSCESS INTRAOR
D4211	GINGIVECTOMY/PLASTY PER TOOT	D7520	INCISION AND DRAINAGE OF ABSCESS EXTRAOR
D4240	GINGIVAL FLAP PROC W/ PLANIN	D7530	REMOVAL FB SKIN/AREOLAR TISS
D4260	OSSEOUS SURGERY PER QUADRANT	D7540	REMOVAL OF REACTION-PRODUCING FOREIGN BO
D4270	PEDICLE SOFT TISSUE GRAFTS	D7550	REMOVAL OF SLOUGHED OFF BONE
D4271	FREE SOFT TISSUE GRAFTS (INCLUDING DONOR	D7560	MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOT
D4320	PROVISIONAL SPLINTING, INTRACORONAL	D7610	MAXILLA - OPEN REDUCTION, TEETH IMMOBILI
D4321	PROVISIONAL SPLINTING, EXTRACORONAL	D7620	MAXILLA - CLOSED REDUCTION, TEETH IMMOBI
D4341	PERIODONTAL SCALING & ROOT	D7630	MANDIBLE - OPEN REDUCTION, TEETH IMMOBIL
D4910	PERIODONTAL MAINT PROCEDURES	D7640	MANDIBLE - CLOSED REDUCTION, TEETH IMMOB
D7111	EXTRACTION CORONAL REMNANTS	D7650	MALAR AND/OR ZYGOMATIC ARCH OPEN REDUCTI
D7140	EXTRACTION ERUPTED TOOTH/EXR	D7660	MALAR AND/OR ZYGOMATIC ARCH CLOSED REDUC
D7210	REM IMP TOOTH W MUCOPER FLP	D7670	CLOSD RDUCTN SPLINT ALVEOLUS
D7220	REMOVAL OF IMPACTED TOOTH- SOFT TISSUE	D7680	FACIAL BONES - COMPLICATED REDUCTION WIT
D7230	REMOVAL OF IMPACTED TOOTH- PARTIALLY BON	D7710	MAXILLA - OPEN REDUCTION, COMPOUND
D7240	REMOVAL OF IMPACTED TOOTH- COMPLETE BONY	D7720	MAXILLA - CLOSED REDUCTION, COMPOUND
D7241	REMOVAL OF IMPACTED TOOTH- COMPLETE BONY	D7730	MANDIBLE - OPEN REDUCTION, COMPOUND
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	D7740	MANDIBLE - CLOSED REDUCTION, COMPOUND
D7260	ORAL ANTRAL FISTULA CLOSURE	D7750	MALAR AND/OR ZYGOMATIC ARCH, OPEN REDUCT

D7760	MALAR AND/OR ZYGOMATIC ARCH, CLOSED REDU		D7955	REPAIR MAXILLOFACIAL DEFECTS
D7770	OPEN REDUC COMPD ALVEOLUS FX		D7960	FRENULECTOMY/FRENECTOMY
D7780	FACIAL BONES - COMPLICATED REDUCTION WIT		D7970	EXCISION OF HYPERPLASTIC TISSUE, PER ARC
D7910	SIMPLE SUTURE OF RECENT SMALL WOUNDS - U		D7971	EXCISION OF PERICORONAL GINGIVA
D7911	COMPLICATED SUTURING OF WOUND, DIAMETER		D7980	SIALOLITHOTOMY
D7912	COMPLICATED SUTURING OF WOUND, DIAMETER		D7981	EXCISION OF SALIVARY GLAND
D7920	SKIN GRAFTS (WOUNDS), IDENTIFY DEFECT CO		D7982	SIALODOCHOPLASTY
D7940	OSTEOPLASTY FOR ORTHOGNATHIC DEFORMITIES		D7983	CLOSURE OF SALIVARY FISTULA
D7950	MANDIBLE GRAFT			

The “D” codes are to be used when a hospital setting is medically necessary. If a service is rendered in a hospital setting as a typical outpatient clinic visit, and the procedures being performed do not merit additional medical attention or intravenous/general anesthesia, the hospital must bill CPT code 41899 for unlisted dental services. The CPT code for unlisted dental services (41899) cannot be billed in addition to the “D” codes.

The dentists performing the procedures will bill for their professional services separately.

If you have questions regarding the above information, you may contact the Benefits Bureau at (505) 827-3171.

We appreciate your participation in the Medicaid program.